DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

SEP 12 2008

Mr. Stan Rosenstein
Chief Deputy Director of Health Care Programs
California Department of Health Care Services
1501 Capital Avenue, MS 0000
P. O. Box 997413
Sacramento, CA 99859-7413

Dear Mr. Rosenstein:

Enclosed is our final report (Control Number 09-CA-02-06) entitled "Review of California Incentive Payments Paid to Negotiated Rate Providers Participating in the Short Doyle Medi-Cal Program".

We appreciate your letter of August 11, 2008, in which you generally concurred with the findings and agreed, by July 1, 2009, to provide CMS with a State Plan Amendment that describes the State's existing reimbursement methods under the Specialty Mental Health Services Waiver program. In addition, the State agreed to implement controls to ensure that all prior period and current year adjustments are made in accordance with Federal Medicaid requirements, and to modify the overpayment recoupment process to ensure compliance with the Federal Medicaid requirements.

A copy of your letter has been incorporated into this final report.

Sincerely,

Gloria Nagle
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Traci Walter, Audit Coordinator

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

REVIEW OF CALIFORNIA INCENTIVE PAYMENTS PAID TO NEGOTIATED RATE PROVIDERS PARTICIPATING IN THE SHORT DOYLE MEDI-CAL PROGRAM

STATE OF CALIFORNIA
HEALTH & HUMAN SERVICES AGENCY
DEPARTMENT OF HEALTH CARE SERVICES
DEPARTMENT OF MENTAL HEALTH

Control Number: 09-CA-02-06-F

September 2008

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS
CENTERS FOR MEDICARE & MEDICAID SERVICES
SAN FRANCISCO REGIONAL OFFICE

EXECUTIVE SUMMARY

OBJECTIVE

The objectives of this review are: 1) to determine whether there is allowable non-Federal share for the incentive payments received by negotiated rate providers that provided Short Doyle Medi-Cal (SD/MC) mental health services during state fiscal year (SFY) 2000-2001; 2) to determine the source of the non-Federal share; and (3) to identify the total amount of FFP associated with the incentive payments.

BACKGROUND

Title XIX of the Social Security Act (the Act) requires states to share in the cost of Medicaid expenditures and permits states and local governments to participate in the financing of the non-Federal share of Medicaid expenditures. To qualify as the non-Federal share, a certified public expenditure (CPE) must be certified by a contributing governmental entity as representing expenditures eligible for FFP.

California Medicaid beneficiaries may receive mental health services through the Short Doyle Medi-Cal System (SD/MC). Short Doyle Medi-Cal services are provided through county mental health plans (MHPs). The MHPs may directly provide services and/or contract with local providers to provide services. If the MHP contracts with local providers, it selects and credentials its provider network, negotiates rates, authorizes services, and provides payment for services rendered.

The approved California State plan contains only a small part of the reimbursement methodology for negotiated rate providers participating in the SD/MC program. Other parts of the methodology are described in State bulletins and provider notices. Under the approved State plan, MHPs and their local providers may elect to be reimbursed on a negotiated rate basis. The negotiated rate is a fixed prospective rate determined by the county MHP and approved by the Department of Mental Health (DMH). As an incentive for efficient operations, the negotiated rate methodology allows for incentive payments when the negotiated rate exceeds the actual costs of providing services. When the reimbursement to a negotiated rate provider exceeds actual costs, the provider may retain 50 percent of the Federal financial participation (FFP) that exceeds actual costs. The remaining 50 percent of FFP is to be returned to the DMH by way of a credit on future payments to the MHP, and ultimately to CMS on the CMS-64 expenditure report.

The county MHP utilizes a CPE process for reimbursement of the FFP. As outlined in the State plan, the negotiated rates are construed to be actual costs and the county MHPs certify the negotiated rate rather than actual costs. The State plan does not include descriptions of the CPE and cost report and reconciliation processes, nor does it contain a description of the source of the non-Federal share.

The reimbursement process for county MHPs providing SD/MC services is outlined in the steps below.

- Step 1 – The county MHP that selects the negotiated rate provider reimbursement method, submits an application request to the DMH for approval of their negotiated rates.
- Step 2 – Up to four times per month, the county MHP billing office submit claims on behalf of itself and its contract providers to the DMH for processing. The MHP submits a certification document that the claims represent its incurred expenditures. DMH determines whether the MHP has any offsets due to the State and adjusts the MHPs claim if there are any.
- Step 3 – The DMH processes the claims to determine the net amount of funds due on the claims and submits the claims to DHCS.
- Step 4 – The DHCS processes the claims to determine whether the services for which the claims were submitted meet Federal and State program requirements and returns the claims to DMH with an amount of FFP due to the MHP. DHCS reimburses DMH who in turn pays the MHP.
- Step 5 – County MHP submits its cost report to DMH six months following the close of the State fiscal year to determine allowable cost and whether the MHP is entitled to an incentive payment. This process is referred to as the interim settlement.
- Step 6 – Since the portion of the FFP that includes the incentive payment is still in the possession of the MHP, they, in effect, have received the payment. The portion of the FFP to be "returned" will be credited against the future payments to the MHP (see Step 2). At this time, the FFP is returned to CMS by DMH.
- Step 7 – Approximately four to five years following the submission of the cost report, the DMH conducts a compliance audit of the MHP cost report. This process is referred to as the "final settlement".

FINDINGS

The approved California State plan reimbursement methodology for negotiated rate providers does not adequately describe or reflect all components of the State's existing reimbursement methods, policies and practices.

The approved California State plan reimbursement methods that allow mental health plans to certify expenditures above actual cost is inconsistent with existing Federal law.

The State lacks adequate controls to ensure that the FFP portion of overpayments is timely returned to CMS.

RECOMMENDATIONS

We recommend that by July 1, 2009, the State amend its State plan to comprehensively describe the State's existing reimbursement methods, processes, and policies that are not

currently reflected in the approved State plan, to ensure the methodology is consistent with Federal requirements. This amendment should include comprehensive detail regarding the interim payment, reconciliation, and cost-settlement processes for these mental health expenditures.

We recommend that by July 1, 2009, the State implement controls to ensure that the certified public expenditure process used by county mental health plans meets existing Federal requirements.

We recommend that by July 1, 2009, the State implement controls to ensure that all prior period and current year adjustments (including all overpayments) are made in accordance with Federal Medicaid requirements.

THE STATE'S COMMENTS

In a letter dated August 11, 2008, California acknowledges their general agreement with the report's findings and recommendations. The State will, by July 1, 2009: 1) provide CMS with a State Plan Amendment that describes the State's existing reimbursement methods under the Specialty Mental Health Services Waiver program, 2) implement controls to ensure that all prior period and current year adjustments are made in accordance with Federal Medicaid requirements, and 3) modify the overpayment recoupment process to ensure compliance with the Federal Medicaid requirements. A copy of the State's response is attached to the report.

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INTRODUCTION

OBJECTIVE

The objectives of this review are: 1) to determine whether there is allowable non-Federal share for the incentive payments received by negotiated rate providers that provided Short Doyle Medi-Cal (SD/MC) mental health services during state fiscal year (SFY) 2000-2001; 2) to determine the source of the non-Federal share; and (3) to identify the total amount of Federal Financial Participation (FFP) associated with the incentive payments.

BACKGROUND

Certified Public Expenditures

Title XIX of the Social Security Act (the Act) authorizes the Federal Government to reimburse states for the costs necessary to administer their Medicaid programs. Specifically the Act provides for payments to states on the basis of the Federal medical assistance percentage (FMAP) for part of their expenditures for services provided under an approved State plan (42 U.S.C. §1396(b)(1); 1396(g)(1); 1396(d)(a)). The Act requires states to share in the costs of Medicaid expenditures and permits states and local governments to participate in the financing of the non-Federal share of Medicaid expenditures (42 U.S.C. §1396(a)(1)).

California Medicaid Mental Health Services

Medi-Cal beneficiaries may receive mental health services through the Medi-Cal Fee-For-Service system (FFS/MC)[1] or the Short-Doyle Medi-Cal system (SD/MC)[2], which are both administered by the Department of Mental Health (DMH). Services provided through the FFS/MC system are general mental health services offered through individual providers who contract with the Department of Health Care Services (DHCS) or service provided through the managed care health plans. Short-Doyle Medi-Cal services are provided to Medi-Cal beneficiaries through county mental health plans (MHPs). There are 56 MHPs which serve 58 counties. MHPs may directly provide services and/or contract with local providers to provide services. If the MHP contracts with local providers, it selects and credentials its provider network, negotiates rates, authorizes services and provides payment for services rendered.

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[1] The term FFS/MC system refers to a service delivery system as well as a funding source. The FFS/MC services are arranged for by DHCS and defined as general mental health services for those beneficiaries who do not meet the medical necessity criteria to qualify for specialty mental health services. The services are provided by physicians (psychiatrists), psychologists, hospitals, and nursing facilities that contract directly with the DHCS.

[2] The term SD/MC system refers to a county operated delivery system as well as a funding source. The SD/MC scope of services is much broader than those offered under the FFS/MC system in that a broader range of providers may deliver services in various community settings. The major distinction between the FFS/MC and SD/MC services is that SD/MC services are services requiring a specialist in mental health), while FFS/MC services are those that can be provided by a general health care practitioner.

Funding Sources for Short Doyle Medi-Cal Services

Funding for SD/MC services consists of Federal funds and a blending of State General Funds (SGF) and county local funds. Both SGF and county local funds (defined below) are used as the non-Federal share. Each year, State General Funds are appropriated to DHCS for SD/MC services and are passed-through to the Department of Mental Health (DMH). Beginning July 2006, the SGF are now appropriated directly to DMH rather than DHCS. The amount of SGF appropriated is based upon an estimate of how much DHCS would have spent for mental health services funded through the FFS/MC system.[3] In turn, the DMH allocates the local and SGF funds to the county MHPs. Each receives an allocation amount no less than the amount of FFS/MC funds spent in each county during the base year including an adjustment for inflation.[4] The DMH is also given a direct SGF appropriation for SD/MC services. This appropriation is used primarily to cover DMH's administrative costs for overseeing the SD/MC programs at the county level.

The county MHPs may use their SGF allocation or other allowable local funds as the non-Federal share for SD/MC expenditures. The largest source of local funds available to county MHPs for use as the county source of matching funds is realignment funds. These funds are derived from sales tax and vehicle license fee revenues.[5] The amount of funds allocated to each county MHP is determined by a complex formula outlined in the Section 17606.05 of the California Welfare and Institutions Code. The allocation of realignment funds to the county MHPs is done directly by the State Controller's Office. State law establishes the percentage of local funds a county must use as the source of non-Federal match. In State Fiscal Year 2000-2001, counties with a population over 125,000 were required to use ten percent of county funds as the non-Federal match.[6] There is variation among the counties in how much SGF and local funds are used as the non-Federal match. In Fiscal Year 2000-2001, approximately $1.02 billion ($523,810,716 FFP) were spent on Medi-Cal mental health services

Background on the Negotiated Rate Reimbursement Methodology

The State plan contains general provisions describing the reimbursement methodology for SD/MC services, including a description of the negotiated rate reimbursement methods. State statute, along with DMH provider notices and bulletins further detail and define this methodology and the requirements for receiving reimbursement. The

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[3] In 1995, in order to provide counties more flexibility in the use of state funding and to enable more integrated and coordinated care, the State consolidated the FFS/MC and SD/MC funding streams. The SGF appropriation is based on the FFS/MC funding source that is now passed through DMH to the counties.

[4] The base year of State Fiscal Year (SFY) 1994-1995 allocation for FFS/MC was used to determine the amount each county would receive for psychiatric inpatient services and the SFY 1997-98 FFS/MC allocation was used to determine the allocation for professional services.

[5] Realignment funds are collected by the State and allocated to various accounts and sub-accounts in a State Local Revenue Fund. Each county has three program accounts, one each for mental health, social services and health. Counties receive deposits into their three accounts for spending on these programs.

[6] For counties with populations of 125,000 or less, the county match requirements were waived.

negotiated rate reimbursement methodology allows counties and/or their contract providers to be reimbursed a fixed prospective rate determined by the county and approved by DMH. California legislation, Senate Bill (SB) 900 enacted the negotiated rate reimbursement methodology. The initial legislation only permitted fourteen counties to be reimbursed on a negotiated rate basis. It also permitted these fourteen counties to reimburse their contract providers based on negotiated rates. Subsequent changes to the law allowed all other counties the option to reimburse their contract providers based on negotiated rates The amendment to the law, however, still does not permit counties other than the original fourteen to receive reimbursement on a negotiated rate basis.

State Plan Amendment Provisions

The California State Plan Amendment 93-009 describes the reimbursement methodology for SD/MC inpatient and outpatient services. Unless an MHP has elected to be a negotiated rate provider, it is reimbursed the lower of published charges, costs, or the State Maximum Allowances (SMAs) for all Short Doyle Medi-Cal. A MHP may request negotiated rates for some services, but not all. However, the negotiated rate reimbursement methodology is not allowed for hospital administrative days. MHPs may not have a separate negotiated rate for therapeutic behavioral health services.

The State plan sets forth the incentive payment arrangement for negotiated rate reimbursement. If reimbursement to a negotiated rate provider exceeds actual costs in the aggregate, then the negotiated rate provider may retain 50 percent of the Federal financial participation (FFP) that exceeds actual costs. This provision was approved in the State Plan as an incentive for increased productivity and efficiency in the delivery of SD/MC services. The State plan does not explicitly assert that county MHPs use the incentive payment for SD/MC services, nor does it explicitly require the State or the counties to match the funds associated with the payment. However, State law does require that these funds be used exclusively for mental health services and capital outlays. The DMH instructions regarding the rate establishment process for SD/MC negotiated rate providers confirms that the funds must be utilized for mental health services.

The State uses the cost report submitted by each county to determine whether a county is entitled to an incentive payment. The cost report is submitted to the DMH no later than six months after the close of the SFY. The State reviews the cost report to determine whether a county is entitled to an incentive payment (the cost reporting and settlement process is discussed below).

Negotiated Rate Establishment Process

California statute describes how counties may elect and establish the negotiated rate methodology. The DMH issues annual provider notices and bulletins that provide the operational guidance on how counties can elect the negotiated rate reimbursement methodology. This level of operational detail is not contained in the State plan. The MHPs that elect to be negotiated rate providers and the others that contract with local providers on a negotiated rate basis must submit an application to the DMH requesting

approval of their proposed negotiated rates. These applications are due by December 31st of the year prior to the State fiscal year (SFY) in which the rates will apply.

Negotiated rates are established at the service function level. To determine the negotiated rate for each service, a base rate for each service is established.[7] The DMH and each individual county negotiate the rates. The State plan does not provide for this process and each individual counties negotiated rate are not included in the State plan. These rates may change on an annual basis. This base rate is then adjusted by using an inflation factor – the Medical Consumer Price Index for hospital acute inpatient services and the Home Health Agency Market Basket Index for all non-hospital services.

Quantifiable documentation must be submitted to support requests for proposed negotiated rates that exceed prior year costs plus the inflation factor or proposed rates that equal the SMAs. This documentation must include information affecting the cost of delivering services such as, changes in utilization and/or program design, and any other unforeseen factors.

Claims Processing and Payment

Claims for SD/MC services are submitted to DMH for processing and submitted to DHCS for payment. Up to four times a month, county MHPs submit claims to DMH for processing. Each county MHP has a billing office that processes the MHPs and contract providers' claims.[8] A county MHP submits a form (Form MH 1940) certifying that it incurred the expenditures associated with the submitted claims. The certification states that the amount of the claims complies with State law that requires the county to certify to the State that the required matching funds are available prior to the reimbursement of Federal funds.[9]

As part of the processing of claims the DMH subtracts all third party payments and determines the net amount of funds due on the claims. DMH submits the batch of edited claims to DHCS for further processing. DHCS processes the claims to determine whether the services provided meet Federal and state program requirements.[10] DHCS determines whether the claims are approved, denied, or suspended.[11] Once this is determined, it electronically returns the entire batch of claims to DMH with a determination of how much FFP is due the county MHPs. DMH sorts the claims by MHP and determines whether the MHPs have any offsets[12] due to the State. If it is determined that an overpayment exceeds the amount of the claim, the accounting office

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[7] The base rate is determined by taking the most recent cost report and dividing the total adjusted gross cost by the total number of actual service units.

[8] Most MHPs have automated claims systems, some submit paper claims.

[9] Cal. W&I §5718(3)(d)

[10] DHCS determines eligibility, whether there is duplication of services, and to ensure that certain services are not billed simultaneously.

[11] The denied and suspended claims are those that DHCS found to not meet program requirements or are unallowable for other reasons. The MHPs may resubmit those claims that can be amended to be approvable.

[12] Offsets are for overpayments identified during claims processing, final settlement, or the year-end audit.

offsets the entire claim amount and any future claim amount until the overpayment has been paid. In cases where the claims exceed the overpayment, DMH will apply the offset and send an invoice to DHCS for the net claimed amount; DHCS then submits an invoice to the State Controller for payment. Once payment is received by DHCS, it passes the funds through DMH back to the MHPs. It is not explicit as to where the incentive payment goes once it is received by the mental health plans.

Cost Reporting and Settlement Process

The California State plan does not include provisions related to the cost report and settlement process. The DHCS, through the DMH issues annual guidance (in the form of DMH Notices and Letters) on the cost report process and conducts trainings at the county level on how the cost report should be completed. The MHPs are required to submit cost reports to DMH by December 31st following the close of the fiscal year. The cost report package must include separate, detailed cost reports for each MHP and certain contract providers who meet certain requirements. The cost report serves four primary purposes: (1) to compute the cost per unit for each service function; (2) to determine the estimated net allowable Medi-Cal costs (FFP) for each legal entity; (3) to identify the sources of funding; and (4) to serve as the basis for the year-end cost settlement and fiscal audit.

To determine allowable Medi-Cal costs, the cost report first calculates the total allowable cost by taking adjustments for non-mental health related expenses. Once allowable costs are determined, the costs are apportioned between utilization review, administrative, and direct service costs. The direct service costs are then allocated between Medi-Cal and non-Medi-Cal services. To determine the average costs per unit of service, the total costs are divided by the number of service units. The Medi-Cal direct service costs for inpatient and outpatient services are separately aggregated and compared to the negotiated rate (where applicable), the SMAs, and published charges.[13]

At this stage in the process, it is determined whether an incentive payment is due. The cost report determines whether the total cost for all services is less than the negotiated rates. The net amount of this calculation is identified as the incentive payment. Twenty five percent of this amount is identified as the amount of funds to be returned to the Federal government. The MHPs may recoup this portion of FFP, or DMH may use these funds to offset future claims for FFP. The remaining twenty five percent is retained by the county or the legal entity that realized the savings associated with the incentive payment. The final part of the cost report process identifies the source of funds used by the MHPs to pay for Medi-Cal and non Medi-Cal services.

There are two types of cost settlements – the interim settlement and the final settlement. The interim settlement occurs when counties submit the year-end cost reports to the DMH. It is during the interim settlement that it is determined whether counties are

[13] For all services not reimbursed on a negotiated rate basis, reimbursement is the lower of costs, SMAs, or published charges. The cost report calculates the incentive payment and during the final settlement the FFP portion is offset against future claims for FFP or directly returned to CMS.

entitled to an incentive payment (FFP portion only) or must return FFP (offsets) to the DMH. The final cost settlement occurs approximately 4 to 5 years following the submission of the county cost reports. It is during final settlement that the DMH performs compliance audits of the county cost reports. At final settlement overpayment (offsets) may also be identified. There are no readjustments to the rate based on the cost settlement process.

Incentive Payments for Negotiated Rate Providers in State Fiscal Year 2000-2001

In SFY 2000-2001, there were a total of nine county MHPs who elected the negotiated rate reimbursement methodology for some services. There were four additional counties that reimbursed their contract providers on a negotiated rate basis, but were not reimbursed on a negotiated rate basis when they were the provider of services. A total of 126 legal entities (contract providers and MHPs) were reimbursed on a negotiated rates basis. Of this number, only 46 received incentive payments.

The total amount of FFP approved through the Short Doyle Medi-Cal System for SFY 2000-2001 was $1.02 billion. Of this amount, $190,405,992 was paid to negotiated rate providers. The total amount of FFP approved for the incentive payments was $2,448,936. This amount represents approximately 1.3 percent of the total FFP approved for mental health services. Los Angeles County and its contract providers accounted for 75% of the FFP incentive payments.

METHODOLOGY & SCOPE

We conducted our fieldwork July 25 – 28, 2006. To accomplish our objectives we:

- Reviewed applicable State and Federal laws and regulations and the State plan amendment;
- Interviewed DMH and DHCS program and financial staff;
- Reviewed DMH documents, including program instructions, claims processing and cost reporting procedures;
- Reviewed the State's calculation of the projected costs for negotiated rate providers;
- Reviewed the MHPs' certification forms;
- Reviewed cost reports to document whether there was non-Federal share for the incentive payments;
- Reviewed contracts between the DMH and counties; and
- Reviewed county contracts between the MHPs and contract providers.

FINDINGS

I. The approved State plan reimbursement methodology for negotiated rate providers does not adequately describe or reflect all components of the State's existing reimbursement methods, policies, and practices.

Federal Regulations at 42 CFR §447.201(b) require that the State plan describe the policy and the methods used in setting payment rates for each type of service included in the State's Medicaid program. We found that the description of the State's reimbursement methods for negotiated rate providers contained in the existing State plan does not have the level of detail and specificity required by Federal regulations. The State plan fails to describe how the negotiated rates are established. The Plan does not describe the certified public expenditure process used to finance the Medicaid payments for mental health claims. Specifically, it does not comprehensively describe the interim payment, reconciliation, and cost-settlement processes for the CPE-related expenditures.

II. The Approved California State plan reimbursement methods that allow mental health plans to certify expenditures above actual cost is inconsistent with existing Federal law.

Federal Regulations at 42 CFR §433.51(b) state that funds provided by governmental entities may be considered as the State's share in claiming FFP if certified by the contributing governmental entity as expenditures eligible for FFP. Governmental entities may not claim FFP through the CPE process above their actual expenditures. The State's non-compliance with this requirement resulted in negotiated rate providers inappropriately claiming approximately $2.4 million in FFP. We found there were no valid expenditures associated with the incentive payment to serve as an appropriate claim to draw down FFP. The State maintains that it did not provide matching funds for the incentive payment because it interpreted the State plan provisions authorizing incentive payments as a bonus or reward to counties that were able to contain costs below the negotiated rate.

The incentive payments are calculated during the interim settlement of the MHPs cost reports. The cost report identifies the amount of FFP paid for all Medi-Cal services and related costs. The cost report contains specific line items and worksheets used to determine total Medi-Cal costs, the total amount of FFP paid, the total amount of non-Federal share contributed to match the FFP payments and the sources of the non-Federal share. CMS reviewed the cost reports and found that there were no Medi-Cal expenditures associated with the amount identified as the FFP portion of the incentive payments.

III. The State lacks adequate controls to ensure that the FFP portion of overpayments is timely returned to CMS.

These payments are not timely returned because DHCS controls do not ensure compliance with Federal regulations at 42 CFR §433.300(b) that require the DMH, on behalf of the single State Medicaid Agency, refund Medicaid overpayments on the CMS-64 report within 60 days from the date the overpayment was discovered. As a result, the Federal government is losing interest income on the funds that are not timely returned.

State law pertaining to the requirements for returning overpayments does not comply with Federal requirements. The Welfare & Institutions Code provides that county MHPs which do not expend funds in accordance with State and Federal requirements must repay those funds within 30 days from the date it has been determined that funds were not expended in accordance with these requirements. However, if a county MHP fails to repay within that timeframe, State law only requires that the funds be recouped within a timely manner. Federal regulations require the State to refund within 60 days from the date of discovery, any overpayment for Medicaid services (42 C.F.R. §433.300(b)). The Federal share of overpayments subject to recovery must be credited on the Form CMS-64 report submitted for the quarter in which the 60-day period of discovery occurs (42 C.F.R. §433.320).

The DMH process for refunding FFP associated with overpayments also does not comply with Federal requirements. On a weekly basis, the DMH runs a report that provides a listing of outstanding overpayments that must be refunded to the Federal government. When an overpayment exceeds the county claim, the DMH allows an offset for part of the overpayment. If a county's subsequent claim for reimbursement is insufficient to repay the remaining balance of the overpayment, future claims are offset against the overpayment until it is resolved. Because DMH ties the resolution of the overpayment to the county's cash flow some overpayments are not returned to Medicaid on the CMS-64 within the 60-day timeframe. Moreover, the DMH does not notify the DHCS of when it has discovered these overpayments and the process for how it resolves them.

In addition, the DMH claims processing and payment system lacks the functionality to track the date of discovery of overpayments. While the weekly report of outstanding overpayments identifies the amount of the overpayment, it does not identify the date the county discovered the overpayment. Moreover, the system does not save the overpayment reports and the DMH does not retain hard copies of them. Upon review of a weekly overpayment report for the week of October 19, 2006, we identified three county overpayments that had not been returned within the 60-day timeframe. These overpayments totaled $1,080,992.

RECOMMENDATIONS

I. We recommend that by July 1, 2009, the State amend its State plan to include a comprehensive description of the State's existing reimbursement methods, processes, and policies that are not currently reflected in the approved State plan. This amendment should include comprehensive detail of the interim payment, reconciliation, and cost-settlement processes for these mental health expenditures.

The State must amend its State plan to include a more comprehensive description of its reimbursement methodology. The State plan contains only part of the reimbursement methods for negotiated rate providers (other reimbursement provisions are contained in DMH bulletins and notices). These components of the methodology should be explicitly described in the State plan.

II. We recommend that by July 1, 2009, the State amend its State plan to ensure that its reimbursement methodology for SD/MC services is consistent with Federal requirements. The State must ensure that its certified public expenditure process used to finance the non-Federal share of SD/MC services meets current Federal laws and regulations.

Section 4.19-B of the California State plan provides that where negotiated rates exceed actual costs, negotiated rate providers may retain 50 percent of the FFP that exceeds actual costs. When the State reimburses county MHPs under this provision, and the county MHP receives reimbursement above its actual costs, the State is in violation of the Federal requirements of 42 CFR §433.51(b). Under this provision of the regulations, a governmental entity is only entitled to reimbursement equal to its actual costs. The State must amend its State plan to provide that there is an actual expenditure to support reimbursement under the negotiated rate methodology, or it must rescind altogether the existing negotiated rate reimbursement method. Within sixty days from issuance of this report, the State must submit a corrective action plan outlining its timeline for compliance with current regulation.

III. We recommend that by July 1, 2009, the State implement controls to ensure that all prior period and current year adjustments (including all overpayments) are made in accordance with Federal requirements.

DMH should provide a summary of offsets taken against county mental health plans' overpayments as well as any outstanding Medicaid overpayments to DHCS when submitting county claims. The State must refund the Federal share of all outstanding Medicaid overpayments within sixty days following discovery of the overpayment (not when paid by the county MHPs). Within sixty days from issuance of this report, the State must submit a corrective action plan outlining its timeline for implementing this recommendation.

THE STATE'S RESPONSE

In a letter dated August 11, 2008, California acknowledges their general agreement with the report's findings and recommendations. The State will, by July 1, 2009: 1) provide CMS with a State Plan Amendment that describes the State's existing reimbursement methods under the Specialty Mental Health Services Waiver program, 2) implement controls to ensure that all prior period and current year adjustments are made in accordance with Federal Medicaid requirements, and 3) modify the overpayment recoupment process to ensure compliance with the Federal Medicaid requirements. A copy of the State's response is attached to the report.

DHCS
SANDRA SHEWRY
Director

State of California—Health and Human Services Agency
Department of Health Care Services

ARNOLD SCHWARZENEGGER
Governor

AUG 11 2008

Ms. Gloria Nagle
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

Dear Ms. Nagle: Gloria

The California Department of Health Care Services (DHCS) has prepared its response to the Centers for Medicare & Medicaid Services' (CMS) draft report entitled "Report on Review of California Incentive Payments to Negotiated Rate Providers Participating in the Short-Doyle Medi-Cal Program" (Control Number 09-CA-02-06). The DHCS appreciates the work performed by CMS and the opportunity to respond to the draft report.

Please contact Mr. Irvin B. White, Jr., Chief of the Medi-Cal Benefits, Waiver Analysis and Rates Division at (916) 552-9619 if you have any questions.

Sincerely,

Stan Rosenstein
Chief Deputy Director
Health Care Programs

Attachment

1501 Capitol Avenue, Suite 71.6001, MS 0002 • P.O. 997413 • Sacramento, CA 95899-7413
(916) 440-7400 • (916) 440-7404 FAX
Internet address: www.dhs.ca.gov

Response to the Centers for Medicare & Medicaid Services' Draft Report Entitled

"Report on Review of California Incentive Payments to Negotiated Rate Providers Participating in the Short-Doyle Medi-Cal Program"

Recommendation: We recommend that by July 1, 2009, the State amend its State plan to comprehensively describe the State's existing reimbursement methods, processes, and policies that are not currently reflected in the approved State plan, to ensure the methodology is consistent with Federal requirements. This amendment should include comprehensive detail regarding the interim payment, reconciliation, and cost-settlement processes for these mental health expenditures.

Response: In general, the State concurs with CMS' findings. The State will provide CMS with a State Plan Amendment (SPA) by July 1, 2009, that describes the State's existing reimbursement methods under the Specialty Mental Health Services Waiver program.

Recommendation: We recommend that by July 1, 2009, the State implement controls to ensure that the certified public expenditure process used by county mental health plans meets existing Federal requirements.

Response: The State proposes to remove the existing negotiated rate methodology contained in the State Plan thereby eliminating the incentive payment arrangement for negotiated rates and ensuring that payments do not exceed the actual costs. In addition, the Department of Mental Health (DMH) will proceed with submitting the necessary request for approval of proposed Legislation to repeal Welfare and Institutions Code Sections 5705 (a)–(c) and 5716 during the Fiscal Year (FY) 2009-10 Legislation process. In addition, DMH will introduce a proposed rule making package to amend Title 9, California Code of Regulations to eliminate provisions to the negotiated rate.

Recommendation: We recommend that by July 1, 2009, the State implement controls to ensure that all prior period and current year adjustments (including all overpayments) are made in accordance with Federal Medicaid requirements.

Response: By July 1, 2009, the State will modify the overpayment recoupment process to ensure compliance with the Federal Medicaid requirements. Since the audit period (July 25-28, 2006), DMH has implemented significant changes in claims processing and reimbursement practices that include controls to ensure adjustments are made in accordance with Federal regulations.